TAR Instructions

Feburary 2005

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Treatment Authorization Request (TAR) Instructions

Section I. -- Electronic Data Systems (EDS)

Box 1: Claim Control Number

Also called the DCN (Document Control Number). EDS completes this. It consists of a prefix, the calendar year in Julian date, a batch number and a document number in the batch.

Nothing, e.g. notes, county stamps, date stamps, staples etc. should be added or affixed anywhere within or around this area by the provider or Mental Health Plan. * **The one exception would be an appeal TAR. If this is an Appeal TAR, under Box 1 it says "Confidential Patient Information", the provider should add the words "Appeal TAR" under this line.**

Box 2, 3, 4, & 5: These fields are completed by EDS.

Section II. -- Provider

Boxes 6-22:

These are fields the provider is responsible for completing.

In most cases, the instructions for completion of both Acute Day TARs and Administrative Day TARs are the same. Where there are differences, these have been noted.

Box 6: Admit TAR Number (Original authorization number)

This box is left blank. It is not applicable for acute or administrative days in an acute psychiatric inpatient hospital.

Box 7: Admit Date

The provider will enter the date of admission.

Box 8: Authorization Expires

When an Administrative Day TAR is submitted following an Acute Day TAR, this box will be completed with the last date payment was authorized at the acute level of care.

Additionally, if more than one TAR is submitted for the same level of care during a single hospitalization, this box will be completed with the last date of coverage from the previous TAR.

Box 9: Emergency Admit

This box is used on every TAR submission. It should be marked with an **"X"** on every TAR submitted whether for Acute Day TARs, (both planned and emergency admissions) or Administrative Day TARs.

Box 10: Provider Number

Providers received a new alpha code provider number prefix,"HSM", under Inpatient Consolidation; the numeric code stayed the same. This is the only prefix acceptable for mental health services.

Box 10A: Provider Phone Number

Box 10B: Verbal Control

If the provider has received verbal authorization, the number provided by the authorization staff will be entered.

Box 10C: Provider Name and Address

Box 11: Patient Medi-Cal Identification Number and Check Digit

The patient Medi-Cal identification number will be entered. Three identification numbers may be used, the Social Security Number (SSN), the Client Index Number (CIN) or a 14-digit identification number. If a Social Security Number or a Client Identification Number is used, the county code and aid code should be written **above** Box 11. If the patient Medi-Cal Identification number is a 14-digit number, the county code and the aid code are the first 4 digits of the number.

A check digit may be used with the Social Security Number and entered in the check digit box.

The Client Index Number is a 10-digit, but the last digit is a check digit and will be entered in the check digit box.

The 14-digit number will not include a check digit.

Box 12: Pend

A "P" will be entered if the beneficiary's Medi-Cal eligibility is not yet established and the Medi-Cal number is not known. Otherwise the field will be left blank.

Box 13: Sex

The beneficiary's sex will be entered as either "M" for male or "F" for female.

Box 14: Date of Birth

The date of birth is entered in numerical format month, day and year, MMDDYY.

Box 14A: Age

The beneficiary's age is entered.

Box 14B: Patient Name

The beneficiary's last name, first name and middle initial are entered.

Box 15: Medicare Status

If the beneficiary is eligible for Medicare, and Medicare has not been billed the appropriate Medicare status code number is entered.

Box 16: Other Coverage

An "X" is entered if the beneficiary has other insurance or health care coverage.

Box 17: Number of Days

The number of days the provider is requesting authorization on this TAR is entered.

Box 18: Type of Days

The code indicating type of day requested is entered.

"0" for Acute Day
"2" for Administrative Day

Box 19: Retroactive

An "X" will be entered if this request is retroactive i.e. submitted beyond 14 calendar days of discharge, (or another standard as specified in contracts between Mental Health Plans and contract providers).

Box 20: Discharge Date

The date the beneficiary was discharged is entered.

Box 21: Admitting ICD 9-CM

The numeric code for the admitting diagnosis is entered using ICD 9-CM codes.

Box 21A: Admitting Diagnosis Description

The English description of the diagnosis from the ICD 9 CM, code book is entered.

Box 22: Current Diagnosis

The ICD 9-CM for the current diagnosis will be entered.

Box 22A: Patient's Authorized Representative

The name and address (if known) of the beneficiary's authorized representative, representative payee, conservator, legal representative, or other representative handling the beneficiary's medical and personal affairs is entered.

Box 22B: Current Condition and Box 22C: Planned Procedures

The provider enters a thorough description of the current condition, and planned procedures so that authorization staff can determine whether the service is medically necessary.

Box 22D: Signature of Provider and Date

The TAR must be signed and dated by a representative of the provider.

Box 22E: Signature of Responsible Physician

The TAR must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. * **The one exception to this would be an Appeal TAR. If this is an Appeal TAR it does not need the "original" physician's signature. Another person can sign on an Appeal TAR for the physician.**

Box 22F-44A: Providers will leave these fields blank.

Section III. -- Mental Health Plan

A TAR can be utilized to authorize or deny a maximum of 99 days. A Mental Health Plan may choose to specify in contracts with providers a particular number of days less than 99 for which a single TAR can be used. Additionally, providers sometimes request that a TAR be completed for specific increments of time less than 99 days to facilitate their billing process.

Box: Service Category (not numbered at top far left of form).

This field will be left blank.

Box: County Use Only (at top left).

The Mental Health Plan's stamp is entered in this area. This box is used by EDS as a security check. The county code in the TAR Control Number (Box 44) must match the county whose stamp is entered. (Only black or blue ink is acceptable).

This field is also used to do a manual check to ensure that no other providers e.g. Primary Care Case Management Plans (PCCMs) are submitting TARs for acute psychiatric inpatient services for Medi-Cal beneficiaries.

A copy of these identifiers is filed with the Department of Mental Health and the fiscal intermediary.

Box 22F and Overview Boxes 23 - 44A:

If authorization staff find documentation of medical necessity in Current Diagnosis, Current Condition and/or Planned Procedures this should be noted in Box 22F, the County Medi-Cal Consultant area.

Historically, when DHS was reviewing cases while the beneficiary was still in the hospital, the narrative portions of the Current Diagnosis, Current Conditions and Planned Procedures sections were not completed since the DHS Medi-Cal Consultants worked primarily from chart/record documentation. Mental Health plans will want to consider this practice and inform providers if they wish the narrative portions of Current Conditions and Planned Procedures to be completed.

The following procedures apply when reviewing Admission Diagnosis (Box 21), Current Diagnosis (Box 22), Current Condition (Box 22B) and Planned Procedures (Box 22C):

1. The admitting and current diagnosis must be included in the medical necessity criteria.

2. If the review is being conducted while the beneficiary is in the hospital, payment may be authorized up to seven days prospectively or after receipt of services.

3. If the review is being conducted after discharge, authorization will occur after receipt of services.

4. For reviews conducted while the beneficiary is in the hospital, Boxes 23-44A are not completed until the beneficiary is discharged. Authorization staff may review the TAR and chart and authorize either up to 7 days prospectively or after receipt of the services. This is documented in Box 22F, County Medi-Cal Consultant, each time the TAR is reviewed before the beneficiary is discharged.

5. If the TAR is submitted after the beneficiary is discharged, (up to a maximum of 14 calendar days, or anything less as specified by the MHP in a contract with a provider) then authorization staff would complete both Box 22F, the County Medi-Cal Consultant Section, and Boxes 23-44A.

6. For planned admissions, authorization staff will complete Box 22F, the County Medi-Cal Consultant Section, and Boxes 23-44A, authorizing up to a maximum of 7 days prospectively.

7. If authorization staff do not find documentation of medical necessity, they will have a physician review the TAR and any accompanying documentation. If the physician agrees with the authorization staff's findings, authorization will be denied. This can be documented in the County Medi-Cal Consultant Section by the authorization staff.

Boxes 23, 25, 28, and 29: Approval, Denial, Modification, and Deferral

These fields indicate the action the authorization staff is taking on the TAR i.e. "Approve", "Approve as Modified", "Deny" or "Defer".

Authorization staff will put an **"X"** in the appropriate box. Only one of these fields should be completed.

"Approved as Requested" means that all days being requested are authorized.

"Approved as Modified" means that some of the days requested are authorized and some are denied.

"Denied" means that all the days being requested are denied.

"Deferred" means that the authorization staff has insufficient information to complete the TAR and are awaiting additional information. TARs may be deferred for such things as no or an incorrect beneficiary Identification number, awaiting proof of other coverage denial, insufficient documentation, no provider or physician's signature etc.

Boxes 24 & 26: From Through Dates

Boxes 24 and 26 indicate the dates of potential coverage at that level of care by month, day and year. Box 24 is the first date from which services may be authorized. Box 26 is the last date through which services may be authorized.

Most often this is the length of stay i.e. the admission date to the hospital and the day before discharge. However, when acute days are followed by administrative days, the Acute Day TAR would have the last authorized date of service at the acute level of care in Box 26, rather than the date of discharge from the hospital. The Administrative Day TAR would have the first date of service at an administrative level of care in Box 24, not the day of admission to the hospital. This would also apply to a stay that has more than one TAR per level of care.

Box 27: Total Number and Type of Days Approved

The total number of days authorized is entered in Box 27.

The type of days authorized is entered by an **"X"** in the appropriate box. The only two types of days applicable for Mental Health Plans are acute and acute administrative.

Box 30: Days of Hospitalization are being denied

This box is always completed if any days are denied. The number of days being denied is entered. This field is used when all days requested are being denied, or when requested days are both denied and approved.

Box 31: Jackson v. Rank

This box is optional for Mental Health Plans.

Boxes 32-41: Dates of Days Denied

These boxes should be completed for all denied days. These boxes are used when the TAR is "Approved as Modified", and when all the days requested are denied. In both cases enter the dates by month and day. If there are not enough boxes, additional dates are entered in Box 22F, the County Medi-Cal Consultant Section and highlighted.

Box 42: Retroactive Authorization

Mark with an "X" the reason retroactive authorization is being used as specified below.

First Box: When certification has been delayed from the County Welfare Department.

Second Box: This field will not be used by Mental Health Plans.

Third Box: This field will not be used by Mental Health Plans.

Fourth Box: When the beneficiary concealed their status as a Medi-Cal beneficiary.

Fifth Box: When there has been a natural disaster.

Sixth Box: When there are other circumstances beyond the provider's control which have been reported to an appropriate law enforcement or fire agency when applicable.

Box 42A, 43: Signature and Staff identifier

The TAR is completed with the signature of the authorization staff (Box 42A). The fields marked Chart Reviews and Review Comments Indicator are not fields that Mental Health Plans will use. Box 43, the authorization staff's identifier, is an optional field for use by the Mental Health plan if desired.

Box 44: Date and TAR Control Number (TCN)

The date the authorizing staff completed the TAR is entered in Box 44 by month, day and year.

The first two digits of the TCN are always "92" or "89" and they are preprinted on the 18-3 TAR form. The third and fourth boxes are completed with **your** two digit county code. This is followed by a unique six digit imprinted number. The final box on the TCN must be completed with the number "5". TARs ordered after spring of 1996 may have the number "5" imprinted in the final box.

TAR Review by Authorization Staff

The following provides background and explanations on key items on the TAR. It can serve as a guide for authorization staff as they review TARs.

Mental Health Plan authorization staff who complete TARs i.e. authorize payment while the beneficiary is in the hospital, and who do more than one review of the TAR will find that some of these fields will not be completed upon the first review.

When reviewing TARs be aware that separate TARS must be submitted in each of the following situations:

a. For an Emergency admission, 14 Calendar Days following Discharge or a standard less, as specified in a contract between a Mental Health Plan and a provider.

b. Planned admission of a beneficiary.

c. Continued stay following a planned admission.

d. Situation's in which Aid/Paid Pending is granted.

e. Every 99 days of continuous service if the hospital stay exceeds that period of time.

f. Distinct levels of care e.g. Acute Day or Administrative Day during a single hospital stay.

g. When providers submit appeals for days, which a Mental Health Plan has denied.

h. When providers submit appeal TARs that have non-consecutive days.

Box 6: Admit TAR Number

This box is not applicable for acute or administrative days in an acute psychiatric inpatient hospital. If the provider has filled it in, the TAR should either be sent back to the provider for correction or marked out.

Box 8: Authorization Expires

For an Administrative Day TAR that follows an Acute Day TAR, this box should be completed with the last acute day for which payment was authorized.

Additionally, for both Acute Day and Administrative Day TARs this box is completed if the TAR is not the first TAR submitted for that level of care during this hospitalization. The date the previous TAR expired will be entered.

Box 9: Emergency Admit

This box should be marked with an **"X"** on every TAR submitted whether an Acute Day TAR, (either planned or emergency admission) or an Administrative Day TAR.

Box 10: Provider Number

The alpha prefix will be HSM followed by a 5 digit numeric number and 1 alpha character. The Mental Health Plan is authorized to take action on an 18-3 TAR only if the prefix of the provider number is HSM.

Border community hospitals alpha prefix will be HSM followed by a 6 digit numeric number and an "X" at the end. The "X" at the end of the provider number will always indicate a border community hospital.

Box 10B: Verbal Control

Mental Health Plans have the option to verbally authorize payment. If they choose to do so they will give the provider a number to enter in this field. DHS Field Office Staff had a series of numbers not necessarily related to the TCN that they used only for verbal control. When they gave a number out for verbal authorization it was logged into a record book with the pertinent data e.g. name of provider, date etc.

Once a TAR has been verbally authorized, it cannot be denied or modified based on later written material.

Additionally, confusion can result when a provider thinks they have asked for a verbal authorization, and the authorization staff believes the provider has asked for and received verbal consultation on a particular case.

Box 11: Medi-Cal Identification Number

The Patient Medi-Cal Identification number is one of three numbers. Most often it is the beneficiary's 9-digit SSN. If so, the county code and the aid code will be entered **above** Box 11. Some providers may use check digits with SSNs in which case a check digit will be entered in the check digit box to the far right of Box 11.

The Medi-Cal identification number may also be a 10-digit CIN. If the Medi-Cal number is a CIN, the last digit is a check digit and entered in the check digit box. The county code and the aid code will be entered **above** Box 11.

Occasionally, the Patient Medi-Cal Identification number is the 14-digit number that includes the county code and the aid code as the first 4 digits of the number.

Adding the county code and aid code to the beginning of either the SSN or the CIN should not create the 13-digit number. The EDS system will not recognize these as bona fide beneficiary identification numbers and the TAR will be rejected.

In all cases the numbers will be entered starting on the farthest left field of Box 11. Check Digits will be entered in the Check Digit Box at the far right of Box 11.

For the beneficiaries whose county of residence is San Mateo or Solano, the Mental Health Plan authorization staff will only process a TAR if the beneficiary is <u>not</u> a member of the County Organized Health System. Membership status can be determined by looking at the county code.

Acute Psychiatric Inpatient services for individuals eligible for the County Medical Services program (CMSP) will go through the TAR process although reimbursement for these services will not come out of the county allocation. CMSP participation can be determined by the aid code.

(* Note: If CMSP clients are applying for Medi-Cal eligibility be aware that this may be retroactive and change CMSP status.)

Box 12: Pending Medi-Cal

Mental Health Plans have the option to complete TARs for beneficiaries who have applied for Medi-Cal, but for whom there is not yet a determination of eligibility.

(Note: DHS' practice was <u>not</u> to review TARs for beneficiaries whose Medi-Cal was pending, since a certain number of these TARs were never used because the beneficiary ultimately did not receive Medi-Cal.) Additionally, no county or aid code will be available until a Medi-Cal identification number has been issued.

If Mental Health Plans choose to continue the DHS practice of not reviewing these TARs, they may also want to consider following DHS' procedure of date stamping and deferring the TAR. Date stamping and officially deferring the TAR gives the providers a track of their timeliness in submitting the original documentation.

Box 15: Medicare Status

If Medi-Care has been billed, nothing will be entered in this box. If the beneficiary is eligible for Medicare, and Medicare has not been billed this will be indicated in Box 15, Medicare Status Code. Mental Health Plans can check eligibility either by using the Automated Eligibility Verification System (AEVS) or a Point of Service (POS) device.

Codes are as follows:

Code	Description
YO	Under 65, does not have Medicare coverage
Y1	Benefits exhausted
Y2	Utilization Committee denial or physician non-certification
Y3	No prior hospital stay
Y4	Facility denial
Y5	Non-eligible provider
Y6	Non-eligible recipient
Y7	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-Covered Services
Y9	PSRO denial
Z1	Medi/Medi Charpentier: Benefit Limitations
Z2	Medi/Medi Charpentier: Rates Limitations
Z3	Medi/Medi Charpentier: Rates and Benefits

Charpentier situations involve the use of specified medical equipment and, according to DHS, are not relevant for acute psychiatric services.

TARs requesting Acute Day services for beneficiaries with both Medicare and Medi-Cal coverage should be refused unless the beneficiary has exhausted their Medicare benefits for acute psychiatric inpatient services, currently a lifetime total of 190 days.

Mental Health Plans should review Administrative Day TARs for those beneficiaries who have both Medicare and Medi-Cal.

Mental Health Plans may choose to defer these Administrative Day TARs until they received "proof of other coverage denial".

Deferring Medi-Cal Administrative Day TARs for clients who have both Medicare and Medi-Cal coverage is now a MHP option. If providers have complied with the documentation requirements for administrative days, and have completed their portion of the TAR according to instructions, and the MHP has received the TAR in a timely manner, the MHP can authorize payment for administrative days. MHPs can then submit the TAR to EDS without waiting for the "proof of other coverage denial." In any case, EDS will not pay the provider's claim unless "proof of Medicare coverage denial or exhaustion" accompanies it.

Box 16: Other Coverage

The provider will enter an "X" in box 16 if the beneficiary has other insurance or health care coverage. Other coverage includes PHPs/HMO plans that do not provide Medi-Cal coverage and insurance carriers.

Mental Health Plans will have the option to review and complete TARs for these beneficiaries either upon submission of the TAR or upon receipt of "other coverage denial".

DHS' practice was <u>not</u> to review TARs for beneficiaries with other coverage until the other coverage has been billed and proof of "other coverage denial" in the form of a denial letter from the carrier or PHP/HMO is submitted with the TAR. Therefore, all these TARs were reviewed after the beneficiary was discharged from the hospital.

Denial letters should include: Name and address, statement of denial because of non-covered services, recipient's name, code number for beneficiary's health plan, date(s) the service(s) was not covered, procedure (service rendered); signature of authorized representative. Additionally, if the claim had been denied for not meeting medical necessity, the provider had to exhaust the other coverage appeal process before DHS would review it.

All other coverage must be billed and denied before Medi-Cal is billed.

Providers are required to submit denial letters with their claims to EDS, and their claims on Medi-Cal will not be processed without such a denial letter.

In making a decision about whether or not to review these TARs before receiving notice of denial, Mental Health Plans may want to consider workload issues i.e. some of these TARs may never need reviewing because the other coverage pays the claim. Mental Health Plans may also want to consider whether to make payment authorization decisions based in part on why the other coverage denied services.

Box 19: Retroactive

If a TAR is presented retroactively, i.e. more than 14 calendar days after discharge of the beneficiary, or lower standard as set by the Mental Health Plan in a provider's contract, authorization staff will evaluate the reason for the retroactive submission.

Mental Health Plan authorization staff must consider the TAR if it is retroactive due to natural disaster or circumstances beyond the control of the provider which have been reported to an appropriate law enforcement or fire agency when applicable. Circumstances which are not considered beyond the control of the provider include, but are not limited to: a) negligence by employees, b) misunderstanding of program requirements, c) illness or absence of any employee trained to prepare MHP authorizations, d) delays caused by the United States Post Office or any private delivery service. The TAR must be accompanied by factual documentation as specified by the Mental Health Plan.

DHS was required to consider TARs for four reasons in addition to natural disasters and circumstances beyond the provider's control. They were: certification of eligibility was delayed by the County Welfare Department; other coverage denied payment of a claim for service; communication with the field office consultant could not be established; and, the beneficiary concealed Medi-Cal eligibility at the time of admission.

A Mental Health Plan may consider processing retroactive TARs for these reasons.

If the MHP chooses to consider retroactive TARs because the beneficiary concealed their eligibility, a signed letter stating the date the provider became aware of the Medi-Cal status with a copy of the Medi-Cal card or Notice of Action must be submitted to the MHP as well as the TAR. Providers can submit TARs to the MHP and claims to EDS on such beneficiaries up to one year after discharge. The TAR must be submitted within 60 days following the certified date of beneficiary identification.

Box 20: Discharge Date

When an Acute Day TAR is followed by an Administrative Day TAR, the discharge date on the Acute Day TAR need not completed if the provider and MHP choose to submit the Acute Day TAR while the beneficiary is still in the hospital on administrative day status.

Box 22B: Signature of Provider and Signature of Responsible Physician

There must be original signatures of both a provider representative and the responsible physician or other licensed personnel with admitting privileges. There are no specifications as to who constitutes a provider representative. In general, the provider's Utilization Review staff signs on this line. Stamped signatures are not acceptable. *** One exception to this would be an Appeal TAR. If this is any Appeal TAR then there is no need for an original signature in the physician's signature box.**

Final TAR Review

Prior to submission, authorization staff should recheck the following:

Box 1: Under this box is a line that says, "Confidential Patient Information". Under this line, if this is an Appeal TAR providers should have entered "Appeal TAR". MHP's may enter this themselves if the provider has left it blank. Also, if this is an Appeal TAR, MHP's should add this information in the County Medi-Cal Consultants box.

Box 7: This box should always be completed with the date the individual has admitted to the facility, regardless of the level of care for this TAR.

Box 8: On an Administrative Day TAR which follows an Acute Day Tar this box should be completed with the last date payment was authorized at an acute level (Box 26 on the Acute Day TAR). If subsequent Administrative Day TARs are submitted, this box should be completed with the last date payment was authorized (Box 26) on the previous Administrative Day TAR.

If the TAR is not the first one submitted for an acute level of care, this box will be completed with the last date payment was authorized (Box 26) on the previous Acute Day TAR.

Box 9: This box should always be marked with an **X** whether an Acute Day TAR is for an emergency or planned admission or the TAR is an Administrative Day TAR.

Box 10: The provider number must have an HSM prefix. If this is a border community provider the number will start with HSM and end with an "X".

Box 11: The county code and aid code is entered **above** Box 11 if the Medi-Cal Identification Number is a Social Security Number or Client Index Number.

Box 17: Number of days requested be entered.

Box 18: Indicates "0" for Acute Day, "2" for Administrative Day.

Boxes 19 and 20 should be completed if applicable. Box 20 may not be applicable if the TAR is an Acute Day TAR being submitted while the individual is still in the hospital on administrative day status or if payment authorization staff denies days before the beneficiary is discharged. If days are denied and the beneficiary has not been discharged this may result in a Frank v. Kizer (Notice of Action) situation.

The provider signature, date and the original signature of the physician or other licensed personnel with admitting privileges is included. ***Unless this is an "Appeal TAR", which does not need an original physician signature.**

If Box 23 (Approved as Requested) is marked with an "X" then:

a. Box 24 = Box 7 or day following Box 8

b. Box 26 = Day prior to Box 20 (unless the length of stay is not the same as dates of potential coverage). This situation would occur with all Administrative Day TARs

c. Boxes 17 and 18 will agree with Box 27

If Box 25 (Approved as Modified) is marked with an "X" then:

a. Box 24 = Box 7 or day following Box 8.

b. Box 26 = Day prior to Box 20. (Unless the length of stay is not the same as dates of potential coverage.) This situation would occur with all Administrative Day TARs.

c. Box 27 = Exact number of days approved (will not agree with Box 17).

d. Box 30 is completed with the number of denied days.

e. The denied dates are in boxes 32 through 41 or if there are not enough boxes, the additional dates are in County Medi-Cal Consultant Section.

If Box 28 (Denied) is marked with an "X" then:

a. Box 24: = Box 7 or day following Box 8.

b. Box 26 = day prior to Box 20 (unless the length of stay is not the same as dates of potential coverage). This situation would occur with all Administrative Day TARs.

c. Box 30 is completed with the total number of days denied.

d. Denied dates are in boxes 32-41 with overflow data in the County Medi-Cal Consultant Section.

9. If Box 29 (Deferred) is marked with an "X" then:

a. The TAR is date stamped.

b. The reason for the deferral is documented.

c. A copy of the deferred TAR is sent to the provider.

EDS' TAR Input Process

EDS screens TARs in several stages for errors.

The first check is a manual check for accuracy. If a TAR is rejected at EDS in this stage, it will be returned to the Mental Health Plan for correction with a cover sheet noting the reason for its return.

Corrections should be made on the original TAR. Corrections must be legible and clear. A copy of it should then be returned to EDS and the Mental Health Plan should keep the original. Whiteout and correction tape cannot be submitted to EDS as they cause an illegible blur when microfilmed. A TAR Update Transmittal (TUT) is not necessary nor is it necessary to make any notation on the copy that this is a second submission, etc. Mental Health Plans will probably want to send a copy of the corrected original to the provider as well.

Once a TAR has completed the manual check for accuracy, it is keyed into the system.

Mental Health Plans will receive a weekly TAR Status Report that shows the status of the TARs that have been key data entered. **TARs that have failed the manual check for accuracy are not included in the report.** Information is presented in the following order:

:

1. County Code
2. Provider Number
3. TAR Control Number (TCN)
4. Recipient Identification
5. Recipient Last Name
7. From Through Dates of Services
8. County Approval Date
9. Document Control Number Date (DCN)
10. Days Difference
11. Disposition
12. Approved Days
13. Error/Code Reason
14. Error Status. (Separate page)

If the disposition is "Approved" or "Denied" no errors have been found and the TAR has been written to the TAR Master File.

If an error is found at this time the TAR is not written to the Master File. The disposition of the error is:

"Error- A", an error has been found on a TAR approved by the Mental Health Plan or "Error-Dn", an error has been found on a TAR denied by the Mental Health Plan or "Error-Df", an error has been found on a TAR deferred by the Mental Health Plan. Each of these TARs has one or more Error/Code Reason(s) specified and an Error Status. If the Error Status is "Pending", no action by the MHP is required because EDS is checking the edits that caused the TAR to error out.

If the Error Status is "Rejected", the Error Code/Reason will provide the Mental Health Plan with information about what error(s) have been detected. The rejected TARs will show on the report, but will **not** be returned to Mental Health Plans by EDS. The MHP should locate its original of the TAR, make the necessary correction(s) or have the provider make the corrections. The MHP should keep the original and resubmit a copy to EDS. Corrections should be legible and clear. EDS will not accept whiteout or correction tape as these will cause the information to blur when the TAR is microfilmed. It is not necessary to connect the corrected TAR in any way with the one in Error Status "Rejected" and no TAR Update Transmittal (TUT) is necessary. Mental Health Plans will probably want to send a copy of the corrected original to the provider as well.

If a provider requests a change in a TAR that has not been entered into the TAR Master File, i.e. the disposition on the weekly TAR Status Report is either "Error-A", "Error-Dn" or "Error-Df", the Mental Health Plan can make approved corrections on their original of the TAR. Corrections should be legible and clear. EDS will not accept whiteout or correction tape as these will cause the information to blur when the TAR is microfilmed. The MHP will keep the original of the TAR. Mental Health Plans will probably want to send a copy of the corrected original to the provider as well. If the corrections are extensive, the MHP may request the provider to submit a new TAR to the MHP. The MHP would then keep the original, send a copy to EDS and send a copy to the provider if desired. It is not necessary to connect either a corrected copy or a new TAR in any way with the one already submitted.

If a TAR was entered in the TAR Master File with the disposition as "Approved" on the weekly TAR status report and changes need to be made to the TAR, then the MHP must complete a TAR Update Transmittal (TUT) form and return it to EDS. A copy of the TAR with changes circled must accompany the TUT. Mental Health Plans will probably want to send a copy of the original with changes to the provider as well. Likewise, if a provider requests a change in a TAR that has been entered into the TAR Master File, the Mental Health Plan completes an TUT showing the approved changes. The TUT and a copy of the original TAR with changes circled are sent to EDS. The MHP keeps the original. Mental Health Plans will probably want to send a copy of the original with changes to the provider as well. "Denied" TARs or "Deferred" TARs **cannot** be TUTed. Also, TARs that have already been paid **cannot** be TUTed. Please note that TUT forms are for the use of Mental Health Plans only and not providers.

Mental Health Plans can obtain further information about the completion of 18-3 TAR forms and TUT forms from Lana Teves, State Department of Mental Health, Medi-Cal Policy and Support Section.

TARs can be ordered by using the reorder form located in the Inpatient/Outpatient Provider Manual. The Inpatient/Outpatient Provider Manual can also be located on the Medi-Cal Website (www.Medi-Cal.ca.gov). TUTs can not be ordered, however they can be duplicated by the MHP's.

Critical TAR Data Fields

The following are the Critical Data Fields EDS will need to process TARs. Some are evaluated during the manual check for accuracy, some during the key data entry process and some during the recoupment procedure after claims have been processed. Claims cannot be processed without a matching TAR entered in the TAR Master File with consistent information.

County Identifier in County Use only Box.

Box 7: Admission Date

Box 9: Emergency Admission

Box 10: Provider Number with HSM prefix

Box 11: Patient Medi-Cal Identification Number

Box 13: Sex

Box 14: Date of Birth and Patient Name

Box 22D: Signature of the Provider Representative, Date Signed, and an Original Signature of the responsible Physician. Unless this is an Appeal TAR, then the original signature of the physician is not needed.

Box 23: "Approved as Requested", or Box 25: "Approved as Modified", or Box 28: "Denied", or Box 29: "Deferred"

Box 24: And Box 26: the "From Through Dates"

Box 27: Type of Days Acute or Acute Administrative for "Approved as Requested" and "Approved as Modified" TARs

Box 30: The Number of Days Denied

Boxes 32-41: Dates of denials

Box 42A: Signature of authorization staff

Box 44: Date Authorization Staff Signed the TAR

The TAR does not have the required preprinted 92 or 89 prefix in the TCN field (next to Box 44).

The TAR does not have a valid county code (01-58) in the 2 spaces following the printed 92 or 89 prefix in the TCN field.

Last Digit called a "Pricing Indicator" on the TCN completed with number "5".

The TAR has attachments. The TAR system is not set up to process attachments.

Inpatient Mental Health Services Program

This section explains how to bill for psychiatric inpatient hospital services, continued stay services and administrative days.

Chapter 633, Statutes of 1994, Assembly Bill 757 consolidated the authorization of Fee-for-Service/ Medi-Cal and Short-Doyle/Medi-Cal psychiatric inpatient hospital services at the county level. Under this program, the State Department of Health Services (DHS) transferred the responsibility for the authorization of *Treatment Authorization Requests* (TARs) for psychiatric inpatient hospital services to the county's Mental Health Plan (MHP). The MHP authorizes psychiatric inpatient hospital service admissions, continued stay services and administrative days for all Medi-Cal recipients based on county of residence. This consolidation affects psychiatric inpatient hospital services only. Non-psychiatric inpatient hospital services are billed according to existing Medi-Cal policies and procedures.

Out-of-State Providers: Psychiatric Inpatient Services Guidelines

Out-of-State providers are not affected by this consolidation program and are to send TARs to the San Francisco Medi-Cal Field Office and use the Inpatient Medi-Cal hospital provider number when billing.

Eligible Recipients

Psychiatric inpatient hospital services are available to Medi-Cal and CMSP recipients only. Medi-Cal recipients enrolled in certain Medi-Cal managed care plans, such as Prepaid Health Plans (PHPs) and the Partnership Health Plan of California – Solano, are not eligible for this program. These plans are to follow the psychiatric inpatient hospital service authorization and billing requirements established under their contract with DHS. (See the *MCP: Prepaid Health Plans (PHPs)* and *MCP: County Organized Health Systems (COHS)* sections in the Part 1 manual.)

Prior Authorization

A *Treatment Authorization Request* form, *Request for Mental Health Stay in Hospital* (TAR Form 18-3), must be completed when requesting authorization for the following admissions:

- Planned admissions for medication treatment (for example, Clozaril) or specialized treatments (for example, electro-convulsive therapy)
- Continued stay services for recipients requiring additional services beyond the planned admission period
- Emergency admissions. Emergency admissions are exempt from prior authorization. However, the hospital must notify the MHP in the recipient's county of residence within 24 hours of admission. If notification is not received within 24 hours, the MHP may deny the hospital stay. (See *California Code of Regulations* (CCR), Title 9, Section 1778.)

If the MHP consultant has previously authorized days for the recipient's admission, but considers continuation of stay not to be medically necessary, the MHP consultant will deny an extension of hospital stay.

Ancillary and Physician Services

Denial of any day of hospitalization will also result in denial or recoupment of payment (if previously made) for all physician or ancillary services rendered that day, including any emergency room, diagnostic and therapeutic or surgical and recovery services.

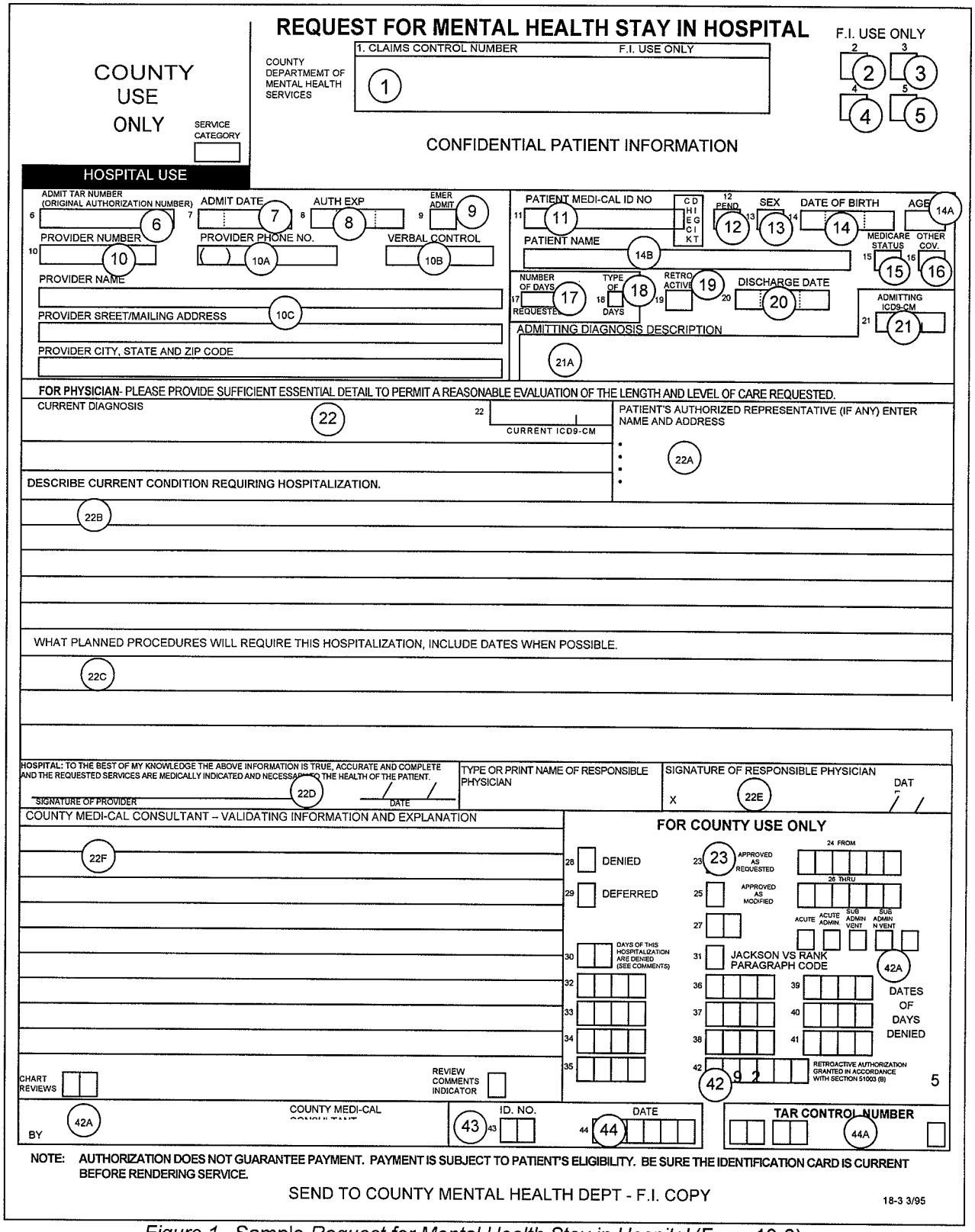
TAR Submissions

Providers are to mail or fax TAR Form 18-3 to the MHP in the recipient's county of residence for approval. The *Inpatient Mental Health Services Program: Plan-Authorization Directory* section of this manual contains a list of MHP mailing addresses, telephone and fax numbers.

Note: Psychiatric inpatient hospital service TARs sent to the Medi-Cal field office will be returned to providers for transmittal to the appropriate MHP. No action is taken on these TARs, other than the placement of a date stamp on the TAR to indicate date of receipt by the field office.

Ordering TAR Form 18-3

TAR Form 18-3 is supplied by Medi-Cal. Use the EDS *Provider Forms Reorder Request* card to order this form. To order, enter "18-3 TAR Forms" next to the quantity ordered on the "18-1" line. Complete the rest of the request as described in the *Forms: Reorder Request* section of the appropriate Part 2 manual.



REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL

F.I. USE ONLY

COUNTY USE ONLY

SERVICE CATEGORY

1. CLAIMS CONTROL NUMBER F.I. USE ONLY

COUNTY DEPARTMEMT OF MENTAL HEALTH SERVICES

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 6

ADMIT DATE 7

AUTH EXP 8

EMER ADMIT 9

PROVIDER NUMBER 10

PROVIDER PHONE NO. 10A

VERBAL CONTROL 10B

PROVIDER NAME

PROVIDER SREET/MAILING ADDRESS 10C

PROVIDER CITY, STATE AND ZIP CODE

PATIENT MEDI-CAL ID NO 11

CD HI EG CI KT

12 PEND 12

SEX 13

DATE OF BIRTH 14

AGE 14A

PATIENT NAME 14B

MEDICARE STATUS 15

OTHER COV. 16

NUMBER OF DAYS REQUESTED 17

TYPE OF DAYS 18

RETRO ACTIVE 19

DISCHARGE DATE 20

ADMITTING ICD9-CM 21

ADMITTING DIAGNOSIS DESCRIPTION 21A

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS 22

CURRENT ICD9-CM

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS 22A

DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION. 22B

WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE. 22C

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER 22D DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN X 22E DAT

COUNTY MEDI-CAL CONSULTANT – VALIDATING INFORMATION AND EXPLANATION 22F

FOR COUNTY USE ONLY

28 DENIED

29 DEFERRED

23 APPROVED AS REQUESTED 23

25 APPROVED AS MODIFIED

27

30 DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS)

31 JACKSON VS RANK PARAGRAPH CODE 42A

24 FROM

26 THRU

ACUTE ACUTE ADMIN. SUB ADMIN VENT SUB ADMIN N VENT

32 36 39

33 37 40 DATES OF DAYS DENIED

34 38 41

35

42 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B) 42

CHART REVIEWS

REVIEW COMMENTS INDICATOR

BY 42A

COUNTY MEDI-CAL CONSULTANT

ID. NO. 43

DATE 44

TAR CONTROL NUMBER 44A

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND TO COUNTY MENTAL HEALTH DEPT - F.I. COPY

18-3 3/95

Figure 1. Sample *Request for Mental Health Stay in Hospital* (Form 18-3).

Explanation of Form Items: Form 18-3

The following item numbers correspond to a circled number on the *Request for Mental Health Stay in Hospital* (18-3) (Figure 1).

Item	Description
1.	**CLAIM CONTROL NUMBER**. Leave blank. For EDS use only.
2. – 5.	**F.I. USE ONLY**. Leave blank.
6.	**ADMIT TAR NUMBER** (ORIGINAL AUTHORIZATION NUMBER). Leave blank. For emergency admits, refer to Item 9.
7.	**ADMIT DATE.** Enter the date of admission.
8.	**AUTHORIZATION EXPIRES.** Enter the date the current TAR expires.

Item	Description
9.	**EMER. ADMIT.** Enter an "X" if the patient was admitted to the hospital.

Providers requesting an approval of admission, transfer or extension of hospital stay on the 18-3 form must complete the following fields accurately:

- The *Patient Medi-Cal ID No.* (Box 11) should be copied from the recipient's Benefits Identification Card (BIC) or the paper Medi-Cal ID card. This is a 10-digit number. Enter the county code and aid code above Box 11.
- The *Provider Number* (Box 10) should be the complete and correct provider number of the hospital using the "HSM" prefix (nine digits).
- The *Number of Days Requested* (Box 17) is the total number of days requested on this extension.
- *Admitting ICD-9-CM* (Box 21) and *Current ICD-9-CM* (Box 22) should be completed using the *International Classification of Diseases, 9th Revision, Clinical Modification.*

Item	Description
10.	**PROVIDER NUMBER.** Enter the number assigned by DHS that uniquely identifies the facility ("HSM" prefix provider number).
10A.	**PROVIDER PHONE NO.** Enter the provider's telephone number; include area code.
10B.	**VERBAL CONTROL.** If a verbal request for a TAR was made, enter the number provided by the MHP consultant. **Note:** A written TAR indicating this number must be submitted to the MHP point of authorization. The Verbal Control Number is not the authorized TAR Control Number and cannot be used for billing.
10C.	**PROVIDER NAME AND ADDRESS.** Enter the name of the hospital, street address, city, state and ZIP code.
11.	**PATIENT MEDI-CAL ID NO. and CHECK DIGIT.** When entering the recipient identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. The county code and aid code must be entered just above the recipient *Medi-Cal ID No.* box. Please do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the *Medi-Cal ID* field or in the *Check Digit* box.
12.	**PEND.** Enter a "P" if the patient's Medi-Cal eligibility is not yet established and the Medi-Cal number is not known. Otherwise, leave blank.

Item	Description

13. **SEX.** Enter the patient's sex:

    - "F" for female
    - "M" for male

14. **DATE OF BIRTH.** Enter the patient's date of birth (month, day, year).

14A. **AGE.** Enter the age of the patient.

14B. **PATIENT NAME.** Enter the patient's last name, first name, and middle initial.

15. **MEDICARE STATUS.** If Medicare is not billed, enter the appropriate Medicare status code number. See the *UB-92 Completion: Inpatient Services* section in this manual for a listing of Medicare Status Codes.

    Note: If the Medi-Cal eligibility verification system indicates the recipient has Medicare coverage, and Medicare is not billed, the Medicare status code must be other than "under age 65, does not have Medicare coverage."

    MHPs do not process TARs for recipients who have Medicare Part A coverage unless their benefits have been exhausted.

Item	Description
16.	**OTHER COVERAGE.** Enter an "X" if the recipient has other insurance or Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) which provide all or most of the recipient's health care needs. Note, however, that providers should refer recipients with PHP/HMO coverage to their PHP/HMOs for treatment, except for emergencies. Refer to the *Other Health Coverage (OHC) Guidelines for Billing* section and the *MCP: Prepaid Health Plans* sections of the Part 1 manual. In all cases, when recipients have OHC, providers must bill the insurance carrier or PHP/HMO prior to billing Medi-Cal. This also applies to recipients with Medicare coverage. Claims for recipients with OHC will be denied unless proof of "Other Coverage denial" in the form of a denial letter from the carrier or PHP/HMO is submitted with the Medi-Cal claim. Denial letters must include: PHP or HMO name and address, statement of denial because of non-covered service(s) • Recipient's name • Code number for recipient's health plan • Date(s) the service is/was not covered • Procedure (service rendered) • Signature of authorized PHP/HMO representative Refer to the *Eligibility: Recipient Identification* section in the Part 1 manual, for eligibility verification procedures. For OHC coding information, refer to the *Eligibility: Services Restrictions* section in the Part 1 manual.

Item	Description

17. **NUMBER OF DAYS.** Enter the number of days requested on this TAR, for example, 3.

18. **TYPE OF DAYS.** Enter the code indicating type of days requested:

    0 Acute
    2 Administrative

19. **RETROACTIVE.** Enter a capital "X" if this request is retroactive.

20. **DISCHARGE DATE.** Enter the date the patient was discharged from the facility.

21. **ADMITTING ICD-9-CM.** Enter the numeric code for the admitting diagnosis using the ICD-9-CM code book.

21A. **ADMITTING DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE.** Always enter the English description of the diagnosis from the ICD-9-CM code book.

22. **CURRENT DIAGNOSIS.** Current diagnosis and medical justification – provide sufficient medical justification for the MHP consultant to determine whether the service is medically justified. If necessary, attach additional information.

    Enter the current ICD-9-CM code in Box 22.

22A. **PATIENT'S AUTHORIZED REPRESENTATIVE.** Enter the name and address (if known) of the patient's authorized representative, representative payee, conservator over the person, legal representative, or other representative handling the recipient's medical and personal affairs.

22B. **DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION.** Enter sufficient information for the MHP consultant to determine if the services are medically necessary.

Item	Description
22C.	**WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE.** Enter the recipient's plan of care and dates when services will be performed.
22D.	**HOSPITAL.** Must be signed and dated by a representative of the hospital.
22E.	**SIGNATURE OF RESPONSIBLE PHYSICIAN.** Must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. The provider assumes full legal responsibility to Department of Mental Health for the information provided by the representative. Original signatures are required.
22F.	**COUNTY MEDI-CAL CONSULTANT – VALIDATING INFORMATION AND EXPLANATION.** Leave blank; for MHP use.
23. – 42.	**FOR COUNTY USE ONLY.** Leave blank; for MHP use. (This section will contain the decision of the MHP consultant.)
42A.	**COUNTY MEDI-CAL CONSULTANT.** Leave blank. Signature block for MHP use.
43. – 44.	**ID. NO./DATE.** MHP consultant completes.
44A.	**TAR CONTROL NUMBER.** This number is imprinted on the form and will have the prefix "92." The two-digit county code is added after the prefix "92" by the MHP consultant.

Medical and Psychiatric Services: TAR Submission

For recipients requiring both medical and psychiatric services, providers must determine which service is more urgent to prevent death, serious bodily impairment and/or relieve severe pain, and submit the TAR to either the Medi-Cal field office or the MHP.

- If the recipient needs medical or surgical intervention first, providers should submit a TAR Form 50-1 to the Medi-Cal field office.

- If the recipient needs acute psychiatric intervention for protection of life, the provider, if authorized to render psychiatric inpatient hospital services, should submit a TAR Form 18-3 to the MHP in the recipient's county of residence. Otherwise, if the provider is not authorized to render psychiatric inpatient hospital services, the recipient should be referred to the appropriate facility licensed to render such services.

Note: Non-psychiatric inpatient services are authorized by the Medi-Cal field office following current TAR form policies and procedures. Out-of-State providers are to use the TAR (50-1) and submit TARs to the San Francisco Medi-Cal Field Office.

Mental Health Provider Number

The mental health provider number is identified by the prefix "HSM" followed by the inpatient Medi-Cal provider number. For example, if a provider's inpatient Medi-Cal provider number is ZZT31234F, the provider's mental health provider number is HSM31234F.

The mental health provider number must be used only when requesting TAR authorization and billing for psychiatric inpatient hospital services.

Out-of-State Providers

Out-of-State providers are to continue to use their inpatient Medi-Cal provider number.

Billing Procedures

Psychiatric inpatient hospital services are billed on the *UB-92 Claim Form.* When completing the claim, providers must enter the mental health provider number ("HSM" prefix) in the *Provider Number* field (Box 51) and the MHP TAR number in the *Treatment Authorization Codes* field (Box 63).

Submitting Claims

All claims are submitted to EDS for processing.

Revenue Codes

The following revenue codes are used to bill for psychiatric inpatient hospital services:

Code	Description
114	Room and board, private, psychiatric
124	Room and board, semi-private, 2-bed, psychiatric
134	Room and board, semi-private 3- or 4-bed, psychiatric
154	Room and board, ward (medical or general), psychiatric
169	Room and board, other (use to bill administrative day[s])
204	Intensive care, psychiatric

Hospitals with a separately negotiated rate for services to children and adolescents will receive that rate when revenue codes 114, 124, 134 or 154 are billed for a recipient who is 18 years of age or younger or who is under the specific age negotiated between the mental health plan and the hospital.

Ancillary Charges

Claims must also show the ancillary charges as part of the total charges billed, even though the reimbursement is an all-inclusive rate for bed and ancillary charges.

Take-home Drugs

Claims for take-home drugs billed with Medicare deductibles and/or coinsurance should be submitted using the provider's non-contract (non-HSM) provider number. If billed under the HSM number, the claim will be denied.

Note: HSM numbers may be used for billing take-home drugs on a straight Medi-Cal mental health inpatient claim, together with revenue codes and other ancillary charges.

Reimbursement Rates

Medi-Cal reimbursement is based on per diem rates and is not subject to retrospective cost settlement. The per diem rate for those hospitals that render a high volume of Medi-Cal services is negotiated by the county where the hospital is located. The per diem rate for hospitals that do not have a contract with a county is established by the Department of Mental Health using a weighted average of negotiated rates within a geographic region.

Professional Services Billed Separately

All rates for the preceding revenue codes include bed and ancillary charges only. Professional services, such as psychiatry and psychology, must be separately billed.

Disproportionate Share Hospitals

Disproportionate share hospitals are automatically paid at their regular payment rates for all disproportionate share-eligible days.

Reimbursement Restrictions

Reimbursement will be denied for inpatient hospital services rendered to the following recipients:

- Patients 22 – 64 years of age who reside in private psychiatric hospitals that are Institutions for Mental Diseases (IMDs)
- Patients 22 – 64 years of age who reside in state mental health hospitals when they are temporarily released to an acute care hospital

Administrative Days

Revenue code 169, currently used to bill for acute administrative days, is also used to bill for psychiatric acute administrative days. Except for reimbursement rate and authorization, all Medi-Cal policies and procedures for billing acute administrative days apply to psychiatric acute administrative days.

Psychiatric acute administrative days billed with the mental health provider number "HSM" prefix are reimbursed at an all-inclusive rate not to exceed 125 percent of the current administrative day rate. This rate includes bed and ancillary charges.

Completing the Claim

Psychiatric acute administrative days are subject to authorization by the appropriate MHP field office. Allowable ancillary charges must be shown as part of the total charges billed although not paid separately. Claims submitted with both psychiatric administrative days and any other revenue codes will be denied.

Non-Psychiatric Administrative Days

Non-psychiatric administrative day claims are reimbursed based on the rates currently on file.

Crossover Inpatient Services: Deductibles and Coinsurance

There is no change in billing psychiatric inpatient crossover claims for coinsurance and deductibles. Providers should continue to use their non-HSM inpatient provider number for these claims. These claims will be cut back to zero with RAD code 469 (payment was reduced to zero because Medi-Cal's maximum reimbursement equals Medicare's payment on this claim).

TAR Appeals and Fair Hearing Requests

The MHP is responsible for first level TAR appeals. The Department of Mental Health processes second level TAR appeals. There is no change for fair hearings.

Claim Inquiries and Appeals

All psychiatric inpatient hospital service claim inquiries and appeals are processed through EDS regardless of date of service.

UB-92 Tips for Billing: Inpatient Services

This section describes *UB-92 Claim Form* fields that must be completed accurately and completely in order to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *UB-92 Completion: Inpatient Services* section of this manual.

Common Billing Errors

Field	Description	Error
24 – 30	Condition Codes	Omitting codes or entering **a Medi-Cal local** billing limit exception code (**X0**, **X**1 – **X**9). **Billing Tip: Billing limit exception codes changed to national delay reason codes for dates of service on or after September 22, 2003. In addition, placement of the code on the claim changed. The delay reason code is entered in the *Delay Reason* field (Box 31) of the claim. Refer to *Code Correlation Guide* at the end of the *UB-92 Completion: Inpatient Services* section of this manual.** Enter codes in numeric-alpha order. For example, 80, 82, **A**1.
39 – 41 (A – D)	Value Codes and Amount (Patient's Share of Cost)	Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code. **Billing Tip**: Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest level. Value code information is required for Medicare/Medi-Cal crossovers.
50 (A – C)	Payer	Missing all payer information. Billing Tip: Be sure to enter the "I/P" indicator.
51 (A – C)	Provider Number	Missing or incorrect provider number. **Billing Tip:** Enter your Medi-Cal nine-digit provider number.
54 (A – B)	Prior Payment (Other Coverage)	Missing prior payment or Other Health Coverage not indicated. **Billing Tip:** Be sure to enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
60 (A – C)	CERT.–SSN–HIC–ID Number	Entering the recipient Medi-Cal ID number incorrectly. **Billing Tip:** Verify that the recipient is eligible for the services rendered by using the POS network or telephone AEVS. Do not enter the Medicare ID number.

Field	Description	Error
63 (A – C)	Treatment Authorization Codes	Entering EVC number instead of the TAR number. **Billing Tip:** The EVC number is only for verifying eligibility and should not be entered on the claim.
80, 81	**Principal Procedure Code**	**Missing or incorrect ICD-9-CM Volume 3 procedure code or a CPT-4/HCPCS procedure code entered.** **Billing Tip: Inpatient providers use ICD-9-CM Volume 3 procedure codes on their claims for dates of services on or after September 22, 2003, instead of CPT-4/HCPCS surgical procedure codes.**
82	Attending Physician ID	Missing or incorrect attending physician's nine-digit Medi-Cal ID number. **Billing Tip:** Do not enter the operating or admitting physician's Medi-Cal nine-digit provider number in this field.
83A 83B	Other Physician ID (Operating Physician Provider Number) Other Physician ID (Admitting Physician Provider Number)	Missing or incorrect operating physician's Medi-Cal provider number. **Billing Tip:** Enter the State license number if the operating physician is not a Medi-Cal provider. Missing or incorrect admitting physician's Medi-Cal provider number. **Billing Tip:** Enter the State license number if the admitting physician is not a Medi-Cal provider.
84	Remarks	Reducing font size or abbreviating terminology to fit in the field. **Billing Tip:** If additional information cannot be completely entered in this field, attach the additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.

Field Completion Reminders

Providers should remember the following when completing the claim form.

- Submit separate claims for inpatient services. Do not combine inpatient and outpatient services on the same claim.
- Enter the complete hospital name, address and ZIP code in the upper left corner of the form (field 1 [*Unlabeled*]).
- The upper middle box (field 2) is reserved for EDS use only. Type only in areas of the claim form designated as fields. Do not type in undesignated white space.
- Enter the three-digit type of bill code (comprised of two-digit facility type and one character claim frequency code) in the *Type of Bill* field (Box 4).
- Draw a line through the entire detail line from the left border of field 42 (*Revenue Code*) to the right border of field 49 (*Unlabeled*). Enter the correct billing information on another detail line. Be sure to use only a blue or black ballpoint pen. Felt-tip pens are unacceptable.
- Include the individual dates of service after entering description of services rendered in field 43 (*Descriptions*) for "from-through" billing.
- Enter your nine-character Medi-Cal provider number in field 51 (Provider Number).

Paper Claim Form Requirements

The following paper claim form requirements and standard billing procedures can speed claim processing and prevent delays. Before submitting claims, check to see that:

- The *UB-92 Claim Form* is printed with "drop-out" ink and that the form meets HCFA standards.
- The original claim is submitted. Carbon copies or photocopies, computer-generated claim form facsimiles or claim forms created on laser printers are not acceptable.
- Individual claim forms are separated. Each claim is processed separately. Do not staple original claims together. Stapling original claims together indicates the second claim is an "attachment," not an original claim to be processed separately.
- All perforated sides are removed. For accurate scanning, be sure to leave a ¼-inch border on the left and right side of the form after removing the perforated sides.
- Information is typed within the designated area of the field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a DOT matrix printer, do not use "draft mode." The characters do not have enough distinction and clarity for the optical character reader to accurately determine the contents.
- All dates are entered without slashes. Do not use punctuation, such as decimal point (.), dollar sign ($), positive (+) or negative (-) symbol when entering amounts.
- Attachments are taped to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.

UB-92 Completion: Inpatient Services

The *UB-92 Claim Form* is used to submit claims for inpatient hospital accommodations (for example, medical/surgical intensive care, burn care, and coronary care) and ancillary charges (for example, labor and delivery, anesthesiology, and central services and supplies).

Most claims for inpatient services can also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

For additional billing information, refer to the *UB-92 Special Billing Instructions for Inpatient Services*, the *UB-92 Submission and Timeliness Instructions* and *UB-92 Tips for Billing: Inpatient Services* sections in this manual.

Note: Certain codes that providers enter on the *UB-92 Claim Form* changed as a result of the federally mandated Health Insurance Portability and Accountability Act (HIPAA), including the following codes for inpatient providers:

- **Revenue codes (previously accommodation codes)**
- **Delay reason codes (previously billing limit exception codes)**
- **Condition codes**
- **Patient status codes**
- **Type of bill codes**

Claims with a "from" date of service on or after September 22, 2003, must include the appropriate national code. Claims for dates of service prior to September 22, 2003, must include the appropriate Medi-Cal local code.

Refer to the *Code Correlation Guide* at the end of this section to see the correlation between local and national codes. A handy *HIPAA In Review* guide also is included at the end of this section that summarizes important HIPAA implementation changes.

Field	Entry
1	HOSPITAL NAME/ADDRESS/ZIP CODE
2	LEAVE BLANK
3 PATIENT CONTROL NO.	PATIENT ACCOUNT NUMBER
4 TYPE OF BILL	TYPE OF BILL
5 FED. TAX NO.	NA
6 STATEMENT COVERS PERIOD FROM / THROUGH	FROM / THROUGH
7 COV D.	NA
8 N-C D.	NA
9 C-I D.	NA
10 L-R D.	NA
11	NA
12 PATIENT NAME	PATIENT'S NAME
13 PATIENT ADDRESS	PATIENT'S ADDRESS
14 BIRTHDATE	DOB
15 SEX	SEX
16 MS	NA
ADMISSION 17 DATE	AD DATE
18 HR	HR
19 TYPE	AD TYPE
20 SRC	AD TYPE
21 DHR	DHR
22 STAT	STAT
23 MEDICAL RECORD NO.	NA
CONDITION CODES 24–30	CONDITION CODES
31	DELAY REASON CODE
32–35 OCCURRENCE CODE / DATE	OCCURRENCE CODES AND DATES
36 OCCURRENCE SPAN CODE FROM THROUGH	NA
37 A B C	NA
38	NA
39–41 VALUE CODES CODE AMOUNT (a–d)	VALUE CODES AND AMOUNTS
42 REV. CD. (1–23)	REVENUE CODE; 001 (line 23)
43 DESCRIPTION	DESCRIPTION OF SERVICE
44 HCPCS / RATES	NA
45 SERV. DATE	NA
46 SERV. UNITS	UNIT OF SERVICE
47 TOTAL CHARGES	SERVICE CHARGE; TOTAL CHARGES (line 23)
48 NON-COVERED CHARGES	NA
49	NA
50 PAYER (A, B, C)	I/P MEDI-CAL
51 PROVIDER NO.	PROVIDER NO.
52 REL INFO	NA
53 ASG BEN	NA
54 PRIOR PAYMENTS	OTHER COVERAGE
55 EST. AMOUNT DUE	NET AMOUNT BILLED
56	NA
57	NA
DUE FROM	
58 INSURED'S NAME	NA
59 P.REL	NA
60 CERT. -SSN-HIC.-ID NO.	MEDI-CAL ID NUMBER
61 GROUP NAME	NA
62 INSURANCE GROUP NO.	NA
63 TREATMENT AUTHORIZATION CODES	TAR CONTROL NUMBER
64 ESC	NA
65 EMPLOYER NAME	NA
66 EMPLOYER LOCATION	NA
67 PRIN. DIAG CD.	PRIM ICD9
68 CODE (OTHER DIAG. CODES)	SEC. ICD9
69 CODE	NA
70 CODE	NA
71 CODE	NA
72 CODE	NA
73 CODE	NA
74 CODE	NA
75 CODE	NA
76 ADM. DIAG. CD.	NA
77 E-CODE	NA
78	NA
79 P.C.	NA
80 PRINCIPAL PROCEDURE CODE / DATE	PRIM ICD9 V3 / SURG/DEL
81 OTHER PROCEDURE CODE / DATE	SEC ICD9 V3 / NA
OTHER PROCEDURE CODE / DATE	NA / NA
OTHER PROCEDURE CODE / DATE	NA / NA
OTHER PROCEDURE CODE / DATE	NA / NA
OTHER PROCEDURE CODE / DATE	NA / NA
82 ATTENDING PHYS. ID	ATTENDING PHYSICIAN PROV. NO
83 OTHER PHYS. ID	OPERATING PHYSICIAN PROV. NO
OTHER PHYS ID.	ADMITTING PHYSICIAN PROV. NO
84 REMARKS	REMARKS/EMERGENCY CERTIFICATION
85 PROVIDER REPRESENTATIVE	X SIGNATURE
86 DATE	DATE

UB-92 HCFA - 1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 1. UB-92: Medi-Cal Required Fields for Inpatient Claims.

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *UB-92 Claim Form* on the previous page. All items must be completed unless otherwise noted.

Note: Items described as "Not required by Medi-Cal" may be completed for other payers, but are not recognized by the Medi-Cal claims processing system.

Although the *UB-92 Claim Form* refers to each field as a "Form Locator," Medi-Cal instructions will refer to it as a "Box."

Item	Description
1.	**HOSPITAL NAME, ADDRESS AND ZIP CODE.** Enter the hospital name, address and five-digit zip code. Please confirm that this information is correct before submitting claims. A telephone number is optional in this field.
2.	**UNLABELED.** For FI use only. This field must be left blank on all claims submitted to Medi-Cal.
3.	**PATIENT CONTROL NUMBER.** This is an optional field that will help you to easily identify a recipient on RTDs and RAs. Enter the patient's medical record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RTD and RA. Refer to the *Remittance Advice Details (RAD) Examples: Inpatient Services* section in this manual for patient medical record number information.
4.	**TYPE OF BILL.** Enter the appropriate three-character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-92 Manual Billing Procedures.* This is a required field when billing Medi-Cal.

4. TYPE OF BILL
114

Item	Description
5.	**FEDERAL TAX NUMBER.** Not required by Medi-Cal.
6.	**STATEMENT COVERS PERIOD (FROM – THROUGH).** In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. The date of discharge should be entered in the *THROUGH* Box, even though this date is not reimbursable (unless the day of discharge is the date of admission). For "From-Through" billing instructions, refer to the *UB-92 Special Billing Instructions for Inpatient Services* section in this manual. **Note:** The "from" date in this field determines whether you must enter national codes or local Medi-Cal codes on your claim. Refer to the *Code Correlation Guide* at the end of this section for information about the specific codes you must bill on your claim.
7.	**COVERAGE DAYS.** Not required by Medi-Cal.
8.	**NON-COVERED DAYS.** Not required by Medi-Cal.
9.	**CO-INSURANCE DAYS.** Not required by Medi-Cal.
10.	**LIFETIME RESERVE DAYS.** Not required by Medi-Cal.
11.	**UNLABELED.** Not required by Medi-Cal.

	Item	Description
	12.	**PATIENT NAME.** Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.
Newborn Infant		When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 12. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims. Refer to the *Obstetrics: UB-92 Billing Examples for Inpatient Services* section in this manual for various billing examples relating to birth. Enter the infant's date of birth and sex in Boxes 14 and 15. Enter the mother's name in Box 58 (*Insured's Name*) and enter "03" (CHILD) in Box 59 (*Patient's Relationship to Insured*).
Organ Donors		When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 (*Insured's Name*) and enter "11" (DONOR) in Box 59 (*Patient's Relationship to Insured*).

Item	Description
13.	**PATIENT ADDRESS.** Not required by Medi-Cal.
14.	**BIRTHDATE.** Enter the patient's date of birth in an eight-digit MMDDYYYY [Month, Day, Year] format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors see Item 12 on a previous page.)
15.	**SEX.** Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the Benefits Identification Card. (For newborns and organ donors see Item 12 on a previous page.)
16.	**PATIENT MARITAL STATUS.** Not required by Medi-Cal.
17 – 18.	**ADMISSION/DATE AND HOUR.** In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows: • Eliminate the minutes • Convert the hour of admission/discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)
19.	**TYPE OF ADMISSION.** Enter the numeric code indicating the necessity for admission to the hospital: Emergency – 1 Elective – 3 Newborn – 4 (used only for baby born outside the hospital in conjunction with appropriate revenue code and source of admission code "4")

Item	Description

20. **SOURCE ADMISSION.** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code "1" or "3" must be entered in Box 19 to indicate whether the transfer was an emergency or elective.

Source of Admission Code	Description
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility

Baby born outside the hospital: In cases where the type of admission code in Box 19 is "4" (newborn [used by Medi-Cal only when baby is born outside the hospital]), submit the claim with source of admission code "4" (extramural birth) in Box 20 and the appropriate revenue code in Box 42.

21. **DISCHARGE HOUR.** Enter the discharge hour as follows:

- Eliminate the minutes
- Convert the hour of discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

If the patient has not been discharged, leave this box blank.

Item	Description

22. **STATUS.** Enter the numeric code explaining patient status as of the "Through" date (Box 6) under "Statement Covers Period."

Code	Explanation
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital for inpatient care
04	Discharged/transferred to an Intermediate Care Facility
20	Expired
* 30	Still patient
* 31	Still patient
61	Discharged/transferred within this institution to hospital-based Medicare-approved swing bed
64	Discharged/transferred to a Nursing Facility certified under Medicaid but not certified under Medicare

* Enter "31" to identify patients still admitted at the end of the billing period. Code "31" is used on the first interim billed. Use code "30" for subsequent billing.

Note: Refer to the *Code Correlation Guide* at the end of this section for information about claims for services rendered prior to September 22, 2003.

Item	Description
23.	**MEDICAL RECORD NUMBER.** Not required by Medi-Cal. This number will not appear on the RTD or RAD for recipient identification. The *Patient Control Number* (Item 3) will appear on the RTD and RAD.
24 – 30.	**CONDITION CODES.** Condition codes are used to identify conditions relating to this bill that may affect payer processing. Although the Medi-Cal claims processing system only recognizes the condition codes below, providers may include codes accepted by other payers in Boxes 24 – 30. The claims processing system ignores all codes not applicable to Medi-Cal. Condition codes should be entered from left to right in numeric-alpha sequence starting with lowest value. For example, if billing for three condition codes, "A1", "80" and "82", enter "80" in Box 24, "82" in Box 25 and "A1" in Box 26. See *Figure 2.*

CONDITION CODES

24	25	26	27	28	29	30
80	82	A1				

Figure 2. UB-92 Claim Form: Condition Codes Example.

Item	Description
24 – 30.	**CONDITION CODES (continued).**

Applicable Medi-Cal codes are:

OTHER COVERAGE. Enter code "80" if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately.

Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual.

EMERGENCY CERTIFICATION. Enter code "81" if billing for emergency services. An Emergency Certification Statement must be attached to the claim or entered in the *Remarks* area. The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim.

Item	Description
24 – 30.	**CONDITION CODES (continued).**

FAMILY PLANNING/CHDP. Enter code "AI" or "A4" if the services rendered are related to Family Planning (FP). Enter code "A1" if the services rendered are Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

Submit a separate claim form for bills that contain more than one FP/CHDP code.

Code	Description
A1	EPSDT/CHDP
A4	Family Planning
AI	Sterilization/Sterilization *Consent Form* (PM 330) must be attached if code "AI" is entered

Note: Refer to the *Code Correlation Guide* at the end of this section for information about claims for services rendered prior to September 22, 2003.

Item	Description

24 – 30. **CONDITION CODES (continued).**

MEDICARE STATUS.
Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the *Condition Codes* fields (Boxes 24 – 30) blank on the *UB-92 Claim Form.* The Medicare status codes are:

Code	Description
Y0	Under 65, does not have Medicare coverage
* Y1	Benefits exhausted
* Y2	Utilization committee denial or physician non-certification
* Y3	No prior hospital stay
* Y4	Facility denial
* Y5	Non-eligible provider
* Y6	Non-eligible recipient
* Y7	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
* Y9	PSRO denial
* Z1	Medi/Medi Charpentier: Benefit Limitations
* Z2	Medi/Medi Charpentier: Rates Limitations
* Z3	Medi/Medi Charpentier: Both Rates and Benefit Limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section in this manual for more information.

Item	Description

31. **DELAY REASON.** Enter one of the following delay reason codes and include the required documentation if there is an exception to the six-month from the month of service billing limit.

Code	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/ Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process	Attachment
11	Other	*Attachment
15	Natural disaster	Attachment

* Documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason "11" without an attachment will receive reimbursement at a reduced rate or it will be denied. Refer to "Reimbursement Reduced for Late Claims" in the *UB-92 Submission and Timeliness Instructions* section of this manual.

Inpatient providers must use claim frequency code "5" in the *Type of Bill* field (Box 4) of the claim when adding a new ancillary code to a previous stay and the original stay was already billed.

Refer to the *UB-92 Submission and Timeliness Instructions* section in this manual, *Figures 2a & 2b,* for detailed information about codes and documentation requirements.

Note: Refer to the *Code Correlation Guide* at the end of this section for information about claims for services rendered prior to September 22, 2003.

Item	Description
32 – 35A-B.	**OCCURRENCE CODES AND DATES.** Occurrence codes and dates are used to identify significant events relating to a bill that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with lowest value. For example, if billing for two occurrence codes "24" (accepted by another payer), and "05" (accident/no medical or liability coverage), enter "05" in Box 32A, "24" in Box 33A. See *Figure 3*.

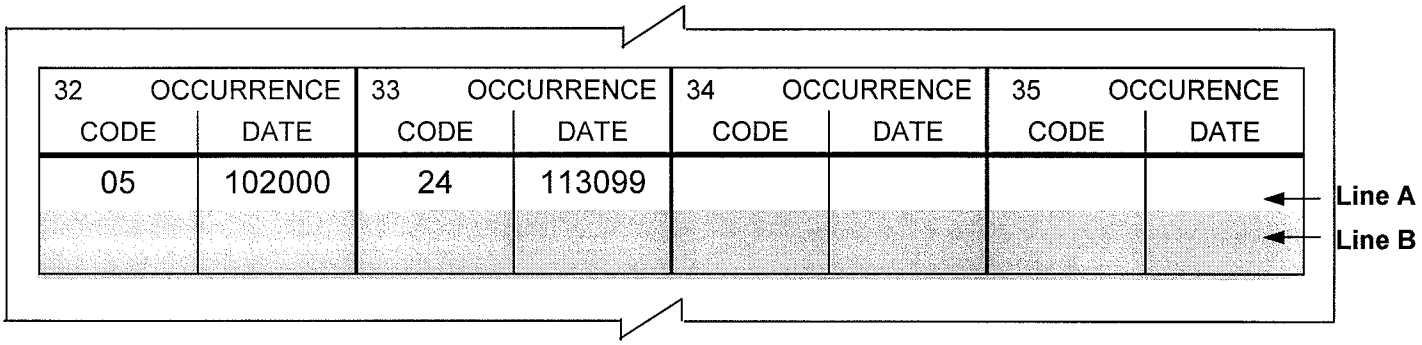


Figure 3. UB-92 Claim Form: Occurrence Codes Example.

Although the Medi-Cal claims processing system will only recognize the codes on the following page, providers may include codes and dates billed to other payers in Boxes 32 – 35. The claims processing system will ignore all codes not applicable to Medi-Cal.

Item	Description

32 – 35A – B. **OCCURRENCE CODES (continued).**

Applicable Medi-Cal codes are:

ACCIDENT/INJURY EMP./NON-EMP./RELATED AND DATE. If condition is an accident or injury and was employment or non-employment related, complete this field. If not an accident or injury, leave blank.

Enter code "04" (accident/employment-related) in fields 32 through 35 if the accident or injury was employment related. Enter one of the following codes if the accident or injury was non-employment related:

Code	Description
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

Item	Description
32 – 35A – B.	**OCCURRENCE CODES (continued).** **DISCHARGE DATE.** In six-digit MMDDYY (Month, Day, Year) format, enter code "42" and the date of hospital discharge when the date of discharge is different from the "Through" date in Box 6.
36A – B.	**OCCURRENCE SPAN CODES AND DATES.** Not required by Medi-Cal.
37 A – C.	**INTERNAL CONTROL NUMBER (ICN)/DOCUMENT CONTROL NUMBER (DCN).** Not required by Medi-Cal.
38.	**RESPONSIBLE PARTY NAME AND ADDRESS.** Not required by Medi-Cal.

Item	Description
39 – 41A – D.	**VALUE CODES AND AMOUNT. Patient's Share of Cost.** Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with lowest value. For example, if billing for two value codes "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in Box 39A and "30" in Box 40A. See *Figure 4*. Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code "23," providers may include codes and dates billed to other payers in Boxes 39 – 41. The claims processing system will ignore all codes not applicable to Medi-Cal.

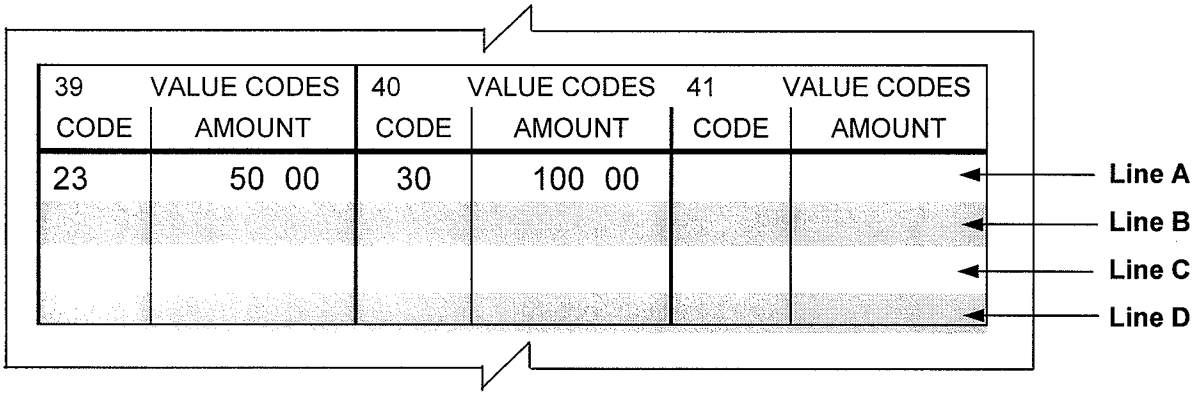


Figure 4. UB-92 Claim Form: Value Codes Example.

Enter code "23" and the amount of the patient's Share of Cost for the procedure or service if applicable. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents even if the amount is even (for example, if billing for $100, enter 10000 not 100). For more information about Share of Cost, see the *Share of Cost: UB-92 for Inpatient Services* section in this manual.

Item	Description
42.	**REVENUE CODE.** Enter the appropriate revenue or ancillary code. Refer to the *Revenue Codes for Inpatient Services* section in this manual. Ancillary codes are listed in the *Ancillary Codes* section of this manual. Refer to the *Code Correlation Guide* at the end of this section for help in determining whether to bill with a National Revenue Code or with a Medi-Cal local code. **Note:** Enter code 001 on the last detail line or on line 23 in this box to designate the total charge line. Refer to the claim example on a previous page for an illustration.
43.	**DESCRIPTION.** Enter the description of the revenue or ancillary code used in Box 42. Refer to the *Revenue Codes for Inpatient Services* and *Ancillary Codes* sections in this manual for the appropriate description.
44.	**HCPCS/RATES.** Not required by Medi-Cal.
45.	**SERVICE DATE.** Not required by Medi-Cal.

Item	Description

46. **SERVICE UNITS (Accommodation Days).** Enter the number of days of care by revenue code. Units of service are not required for ancillary services.

Note: Although this is a seven-digit field, Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on two or more lines.

47. **TOTAL CHARGES.** In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents even if the amount is even (for example, if billing for $100, enter 10000 not 100).

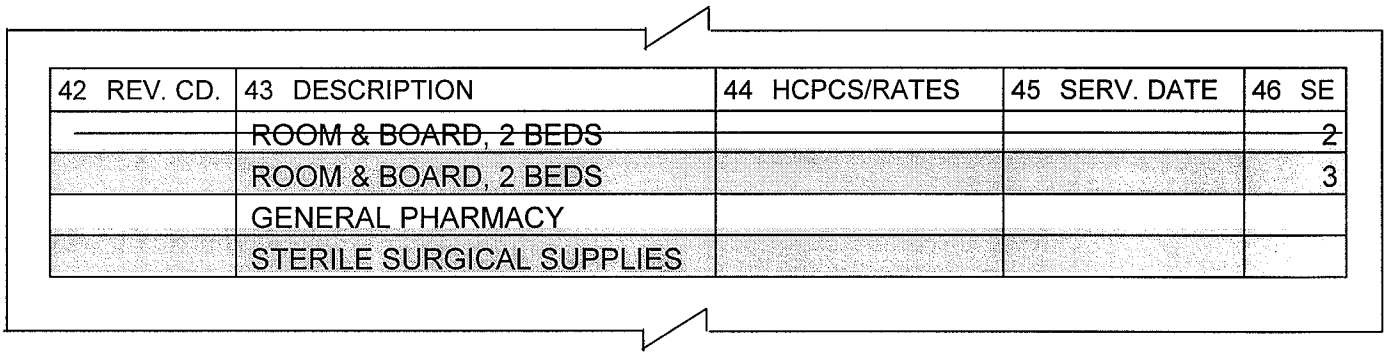
Note: Medi-Cal cannot process credits or adjustments on the UB-92 form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Inpatient Services* sections in this manual for information regarding claim adjustments.

Enter the "Total Charge" for all services on the last detail line or on line 23. Enter code 001 in Box 42 (*Revenue Code*) to indicate this is the total charge line (refer to Item 42 on a preceding page).

Item	Description
48.	**NON-COVERED CHARGES.** Not required by Medi-Cal.
49.	**UNLABELED.** Not required by Medi-Cal.

Note: Providers may enter up to 22 lines of detail data (Items 42 – 49). It is also acceptable to skip lines between data.

To delete a line, mark through the boxes as shown in *Figure 5*. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.



42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SE
	~~ROOM & BOARD, 2 BEDS~~			~~2~~
	ROOM & BOARD, 2 BEDS			3
	GENERAL PHARMACY			
	STERILE SURGICAL SUPPLIES			

Figure 5. UB-92 Claim Form: Line Deletion Example.

Item	Description
50A – C.	**PAYER.** Enter "I/P MEDI-CAL" to indicate type of claim and payer. See *Figure 6*.

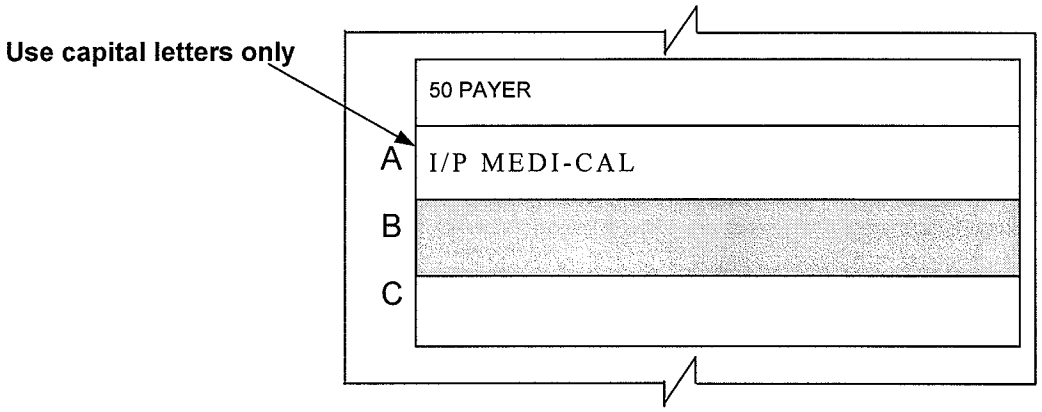


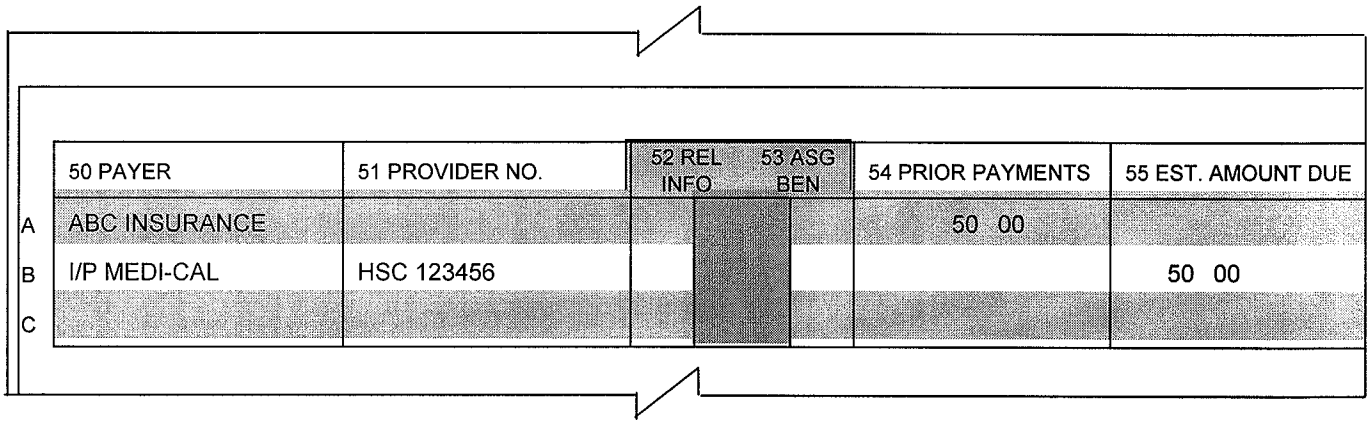
Figure 6. UB-92 Claim Form: Payer Related Information Example.

Important: When completing Boxes 50 – 66 (excluding Boxes 56 and 57) enter all information related to the information in Box 50 (*Payer*) on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.

Figure 7 shows payer-related information for other insurance and Medi-Cal. The name of the other insurance is entered on Line A of Box 50, with the amount paid by other coverage on Line A of Box 54 (*Prior Payments*). All information related to the Medi-Cal billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line.

Note: If Medi-Cal is the only payer billed, all information in Boxes 50 – 66 should be entered on Line A.

Reminder: If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.



	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	ABC INSURANCE				50 00	
B	I/P MEDI-CAL	HSC 123456				50 00
C						

Figure 7. UB-92 Claim Form: Payer Related Information Example.

Item	Description
51A – C.	**PROVIDER NUMBER.** Enter your Medi-Cal provider number; be sure to include all nine characters of the number. **CHECK DIGIT.** A check digit is used by EDS to verify accurate input of the Medi-Cal provider number. Enter the check digit immediately following the last digit of the provider number. The check digit is not a required item. However, it is recommended to ensure payment for the claim is made to the correct provider. If you do not know your check digit, contact the Provider Support Center at 1-800-541-5555.

Provider Number Change

When a provider is assigned a new Medi-Cal provider number by the DHS Master File Unit, a beginning date is listed. When billing for dates of service on or after this beginning date, the new number should be used. When billing for dates of service prior to this beginning date, the old Medi-Cal provider identification number is to be used.

Refer to the *Provider Guidelines* section in the Part 1 manual for provider enrollment contact information.

Billing Services

Providers using a billing service should notify the service to amend its records so that the correct provider number for the date of service will appear on the claim.

Item	Description
52A – C.	**RELEASE OF INFORMATION CERTIFICATION INDICATOR.** Not required by Medi-Cal.
53A – C.	**ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR.** Not required by Medi-Cal.
54A – B.	**PRIOR PAYMENT (Other Coverage).** Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage "payer" (Box 50). Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Leave blank if not applicable. **Note:** For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section in this manual.

Item	Description

55A – C. **ESTIMATED AMOUNT DUE (Net Amount Billed).** In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign ($).

		Total Charges	(Box 47) Revenue code 001
(Minus)	–	Deductions	Share of Cost (Box 39, 40 or 41A – D/ Value code 23) and Other Coverage (Box 54A or B)
(Equals)	=	Net Billed	(Boxes 55A – C)

56. **UNLABELED.** Not required by Medi-Cal.

57. **UNLABELED.** Not required by Medi-Cal.

58A – C. **INSURED'S NAME.** If billing for an infant using the mother's ID or for an organ donor, enter the Medi-Cal recipient's name here and the patient's relationship to the Medi-Cal recipient in Box 59 (*Patient's Relationship to Insured*). See Item 12 on a previous page in this section. This box is not required by Medi-Cal except under these circumstances.

59A – C. **PATIENT'S RELATIONSHIP TO INSURED.** If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [CHILD] or "11" [DONOR]). See Item 12 on a previous page in this section. This box is not required by Medi-Cal except under these circumstances.

Item	Description
60A – C.	**CERT.–SSN–HIC–ID NUMBER.** Enter the 10-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. **Note:** Medi-Cal does not accept HIC Numbers.
Newborn Infant	When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see *Item 12* on a previous page.)
61A – C.	**INSURED GROUP NAME.** Not required by Medi-Cal.
62A – C.	**INSURANCE GROUP NUMBER.** Not required by Medi-Cal.
63A – C.	**TREATMENT AUTHORIZATION CODES.** For services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim.
Extension TAR Control Numbers	Inpatient claims must be submitted with a TAR Control Number, even if an Extension TAR was issued for the same stay. (Enter the Extension TAR Control Number in the *Remarks* area [Box 84].) **Note:** TAR and non-TAR procedures should not be combined on the same claim.

Item	Description
64A – C.	**EMPLOYMENT STATUS CODE.** Not required by Medi-Cal.
65A – C.	**EMPLOYER NAME.** Not required by Medi-Cal.
66A – C.	**EMPLOYER LOCATION.** Not required by Medi-Cal.
67.	**PRINCIPAL DIAGNOSIS CODE.** Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
68.	**OTHER DIAGNOSIS CODE.** If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code.

Item	Description
69 – 75.	**OTHER DIAGNOSIS CODES.** Not required by Medi-Cal.
76.	**ADMITTING DIAGNOSIS.** Not required by Medi-Cal.
77.	**EXTERNAL CAUSE OF INJURY CODE (E-CODE).** Not required by Medi-Cal.
78.	**UNLABELED.** Not required by Medi-Cal.
79.	**PROCEDURE CODING METHOD USED.** Not required by Medi-Cal.
80.	**PRINCIPAL PROCEDURE CODE AND DATE.** Enter the appropriate ICD-9-CM Volume 3 code identifying the primary medical or surgical procedure. In six-digit MMDDYY (Month, Day, Year) format, enter the date the surgery or delivery was performed.
81.	**OTHER PROCEDURE CODES AND DATES.** Enter the appropriate ICD-9-CM Volume 3 code identifying the secondary medical or surgical procedure. **Note:** OB vaginal or cesarean delivery and transplants. Enter the appropriate ICD-9-CM Volume 3 code in either Box 80 or 81.

Item	Description
82.	**ATTENDING PHYSICIAN ID.** On the upper line of Box 82, enter the attending physician's Medi-Cal provider number. If he or she is not a Medi-Cal provider, enter the State license number. Do not use a group provider number. See *Figure 8* below.
83A.	**OTHER PHYSICIAN ID (Operating Physician Provider Number).** On the upper line of Box 83A, enter the Medi-Cal provider number of the operating or delivering physician. If he or she is not a Medi-Cal provider, enter the State license number. Do not use a group provider number. See *Figure 8* below.
83B.	**OTHER PHYSICIAN ID (Admitting Physician Provider Number).** On the upper line of Box 83B, enter the admitting physician's Medi-Cal provider number. If he or she is not a Medi-Cal provider, enter the State license number. Do not use a group provider number. See *Figure 8* below.

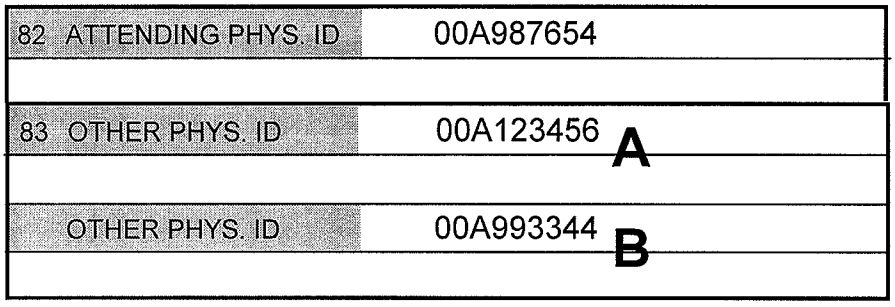


Figure 8. UB-92 Claim Form: Attending, Operating and Admitting Provider.

Item	Description
84.	**REMARKS.** Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim.
85 – 86.	**SIGNATURE OF PROVIDER and DATE.** The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. Signature does not have to be on file at EDS.